# UNITED STATES OF AMERICA
# BEFORE THE NATIONAL LABOR RELATIONS BOARD
# FOURTH REGION

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| COMMUNITY MEDICAL CENTER, INC.[1]<br><br>Employer<br><br>and<br><br>NEW YORK STATE NURSES ASSOCIATION<br><br>Petitioner | Case 4–RC–20954 |

## REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION

The Employer, Community Medical Center, operates an acute-care hospital and other medical facilities in Toms River, New Jersey. The Petitioner, New York State Nurses Association, filed a petition with the National Labor Relations Board under Section 9(c) of the National Labor Relations Act seeking to represent a unit of all full-time, part-time, and per-diem registered nurses (RNs) employed by the Employer.

The Employer contends that RNs who serve as Charge Nurses (CNs) for at least 33 percent of their work time should be excluded from the unit because they are supervisors within the meaning of Section 2(11) of the Act. Additionally, the Employer seeks to exclude Case Managers (CMs) because they do not share a community-of interest with the employees in the petitioned-for unit and because they are managerial employees.[2]

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[1] The Employer's name was amended at the hearing.

[2] The parties stipulated that RNs in the Family Health Center and the Home Health and Hospice department are excluded from the unit. The parties also stipulated to exclude the following job classifications from the unit: Acting Director, Administrative Clinical Coordinator, Administrative Director, Administrator for Nursing Services, Assistant Director, Assistant Director for Patient Care, Clinician Senior, Coordinator, Coordinator-Home Healthcare Aides, Director, Director of Patient Care, Educator RN, Employee Health Nurses, Executive Director, Infection Control Practitioner, Intake RN, Manager-Adult Day Care Program, Massage Therapist, Patient Care Coordinator, Preadmission Testing RN, Process Improvement RN, Program Analyst Senior, Protocol Nursing Data Manager, Quality System Analyst, Senior Administrative Clinical Coordinator, Supervisor-Radiation Oncology, Team Leader-System Business Office, Vice President- Patient Care Services, Vice President -Quality Services, and the Vice Presidents of the remaining six divisions. The parties also agreed to exclude all LPNs, Nursing Assistants, Service Maintenance Technicians, and guards.

The Petitioner has indicated that it will proceed to an election in any unit found appropriate.

A hearing officer of the Board held a hearing, and the parties filed briefs. I have considered the evidence and arguments presented concerning the various issues in this case. As discussed below, in agreement with the Petitioner, I have concluded that all CNs and CMs should be included in the unit, and I have accordingly directed an election in that unit.

To provide a context for my discussion, I will first present a brief overview of the Employer's operations. I will then review the factors that must be evaluated in resolving the supervisory issue, followed by the relevant facts and analysis as to the CNs. I will next present the legal framework, facts, and analysis with respect to the community of interest and managerial status of the CMs.

## I. OVERVIEW OF OPERATIONS

The Employer's hospital has about 600 beds, admits about 30,000 patients per year, and serves approximately 90,000 emergency room patients per year. The main hospital building has five floors and includes 20 in-patient nursing units, an emergency room, and several other departments.

The hospital building is situated on a campus in Toms River that also houses several other buildings. The Riverwood 1 and Riverwood 2 buildings contain various administrative departments. The Bell Building houses the Case Management department, as well as administrative suites for the Employer's Vice Presidents. The Employer also operates other health care facilities at various locations in Toms River, including the Home Health and Hospice Department, the Adult Care Center, and the Family Health Center. RNs work at all of these locations.

The Employer is operated by a Board of Directors. Nancy Wollen is the Employer's Executive Director, and eight Vice Presidents, each in charge of a different division, report to her. These divisions are: Patient Care Services (PCS), Quality Services (QS), Medical Affairs, Financial Services, Support Services, Development, Human Resources, and Information Systems.

Lauren Burke is the Vice President of PCS, which includes the Nursing Services department and 17 other departments. The staff in PCS includes about 40 Nursing Care Directors, 50 Assistant Directors, 850 RNs,[3] 50 Licensed Practical Nurses (LPNs), and 150 Nursing Assistants (NAs).

Judy Conarty is the Vice President of QS. The departments in this division include Case Management, Infection Control, Clinical Resources, Patient Satisfaction, Patient Relations, Patient Safety, Pharmacy, Rehabilitation Services, and Risk Management. Monica Grimes, the Director of the Case Management Department, reports to Conarty. There are about 31 CMs in the Case Management Department.

[3] The record is unclear as to whether this number includes per-diem RNs.

Christine Dodds, a Director in PCS, heads two units, a 29-bed telemetry unit and a 26-bed observation unit. The telemetry unit cares for patients with heart problems, including those patients who have had heart attacks and catheterizations, and provides services including cardiac monitoring, cardiac drips, and medications. The staff in the telemetry unit includes two Assistant Directors, 33 RNs, two LPNs, six NAs, and four secretaries. The observation unit serves as an extension of the emergency room, where staff members observe patients to help determine whether to admit them to the hospital or discharge them. The staff in the observation unit includes 15 RNs, five NAs, and two secretaries.

## II. CHARGE NURSES

### A. Factors Relevant To Evaluating Supervisory Status

The burden of establishing supervisory status is on the party asserting that such status exists. *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 711 (2001). Section 2(11) of the Act sets forth a three-part test for determining whether an individual is a supervisor. Pursuant to this test, employees are statutory supervisors if: (1) they hold the authority to engage in any one of the 12 supervisory functions listed in Section 2(11); (2) their exercise of such authority is not of a merely routine or clerical nature but requires the use of independent judgment; and (3) their authority is held in the interest of the employer. See *NLRB v. Kentucky River Community Care, Inc.*, supra, 532 U.S. at 712-713; *NLRB v. Health Care & Retirement Corp. of America*, 511 U.S. 571, 573-574 (1994).

The statutory criteria for supervisory status set forth in Section 2(11) are read in the disjunctive, and possession of any one of the indicia listed is sufficient to make an individual a supervisor. See *Juniper Industries, Inc.*, 311 NLRB 109, 110 (1993). The Board analyzes each case in order to differentiate between the exercise of independent judgment and the giving of routine instructions, between effective recommendation and forceful suggestions, and between the appearance of supervision and supervision in fact. The exercise of some supervisory authority in a merely routine, clerical, or perfunctory manner does not confer supervisory status on an employee. See *Juniper Industries*, supra at 110. The authority effectively to recommend an action means that the recommended action is taken without independent investigation by superiors, not simply that the recommendation ultimately is followed. See *Children's Farm Home*, 324 NLRB 61 (1997); *Hawaiian Telephone Co.*, 186 NLRB 1 (1970). The Board has an obligation not to construe the statutory language too broadly because the individual found to be a supervisor is denied the protection of the Act. *Azusa Ranch Market*, 321 NLRB 811, 812 (1996). Where the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, the Board will find that supervisory status has not been established, at least on the basis of those indicia. *Phelps Community Medical Center*, 295 NLRB 486, 490 (1989). The sporadic exercise of supervisory authority is not sufficient to transform an employee into a supervisor. See *Gaines Electric*, 309 NLRB 1077, 1078 (1992); *Ohio River Co.*, 303 NLRB 696, 714 (1991), enfd. 961 F.2d 1578 (6th Cir. 1992).

In *Kentucky River*, the Court decided, contrary to the Board, that RNs at a residential nursing care facility were supervisors within the meaning of the Act. In determining that the

nurses were not supervisors, the Board had found, inter alia, that while they directed the work of nurses' aides, this direction did not involve independent judgment because it was by virtue of the nurses' training and experience, not because of their connection with management. The Court acknowledged that the term "independent judgment" is ambiguous with respect to the *degree* of discretion required for supervisory status and recognized that it was "within the Board's discretion to determine, within reason, what scope of discretion qualifies." 532 U.S. at 713. The Court rejected the Board's analysis, however, because the Board erroneously excluded, "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards" from the statutory definition of independent judgment, even where the employees exercised a sufficient degree of discretion to otherwise warrant a supervisory finding. Id. In all other respects, the Court left intact the Board's traditional role in drawing the line between the performance of functions which are clerical and routine and assignment and direction that involve a sufficient element of discretion to confer supervisory status.[4] The Court did not hold that every exercise of professional or technical judgment in directing other employees is necessarily an exercise of independent judgment, but recognized that the Board could determine the degree of independent judgment necessary to meet the statutory threshold for supervisory status. Id. at 714.

### B. The Employer's Contentions

The Employer contends that the CNs are supervisors based on their asserted authority to assign and responsibly direct work and to discipline employees.[5] The Employer does not contend, and there is no evidence, that CNs hire, fire, lay off, recall, or promote employees, effectively recommend such actions, or adjust grievances.

### C. Facts

*Staffing and Scheduling*

The Employer employs about 800 to 900 full-time and regular part-time RNs, including supervisors, in addition to per-diem RNs. Most full-time RNs work three 12-hour shifts per week, either 7:00 a.m. to 7:00 p.m. (day shift), or 7:00 p.m. to 7:00 a.m. (night shift). Some RNs in certain units work five eight-hour shifts per week. Regular part-time RNs work between 20 and 40 hours per week and are required to work a minimum of 40 hours during each two-week pay period. CNs' schedules are the same as full-time RNs'; they generally work three twelve-hour day or night shifts per week.

[4] The Court also indicated that, "the degree of judgment that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and regulations issued by the employer. Id. at 713-714. The Court further suggested that the Board might, "offer a limiting interpretation of the supervisory function of responsible direction by distinguishing employees who direct the manner of others' performance of discrete tasks from employees who direct other employees," as Section 2(11) requires. Id. at 720.

[5] Although the Employer contended at the hearing that CNs have the authority to discipline employees, the Employer did not pursue this contention in its brief.

The record does not describe how nursing schedules are prepared generally in the hospital. PCS Vice-President Burke testified that employees in some units within PCS select their own schedules, but these schedules must be approved by the appropriate Director and Assistant Director. In the telemetry unit, the Assistant Director creates a preliminary four-week schedule after receiving time off requests from staff members, and PCS Director Dodds reviews and approves the final schedule. The CNs are also designated in the schedule.

The number of staff members scheduled for each shift depends on the type of nursing unit and whether it is a day shift or a night shift, with night shifts generally needing fewer staff members. Each unit has a "grid" or chart which states the proper ratio of patients to staff members and is used to determine the staffing levels on each shift. In the telemetry unit, which has 35 beds, 22 RNs work day shift, five to eight per shift, including one CN. Each RN cares for between five and seven patients per shift. 18 of the 22 RNs are trained as CNs and work at times in that capacity. In contrast, in the Critical Care Unit (CCU), there are 25 beds and about 11 RNs, so each nurse cares for fewer patients. In the CCU, the CN handles two patients, in addition to her CN duties, while other RNs handle three patients.[6]

The Employer does not employ any full-time CNs; RNs rotate into the position. The record does not include evidence as to how many RNs serve as CNs throughout the hospital, or how frequently they do so. The record does contain evidence as to some of these issues for several units.

PCS Director Dodds testified that the Assistant Director serves as the CN in her telemetry unit three days a week, and an RN is assigned as CN during the other four days. On Dodds' staff, five nurses, including the Assistant Director, act as CN on the day shift, while six nurses, including the other Assistant Director, act as CN on the night shift. In the observation unit, the Assistant Director is the CN during the day shift, and an RN is designated the CN on the night shift. In this unit, there are four RNs on day shift and three RNs on night shift who are qualified to act as CN.

RN Anna Kokkalis sometimes serves as a CN in the CCU. She testified that she does not serve as a CN on a consistent or regular basis but is simply informed that she will be the CN on certain days. She served as a CN six times in the last four months of 2004. RN Mary Petro, who works in the telemetry unit, testified that she occasionally works as a CN, but she does not learn of this assignment until she arrives for her shift.[7] RN Catherine Heuschkel, who works in a progressive care unit with telemetry, served as a CN in that unit between 20 and 25 percent of the time over the past six months.

*Duties and Responsibilities*

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[6] The record does not indicate to what extent CNs in other units personally care for patients.

[7] Petro testified that she worked as a CN between 40 and 60 percent of the time during the most recent three-month period, although the Employer claimed that she worked as a CN less than 33 percent of the time during two-thirds of that period. No documents were presented on this point.

PCS Vice-President Burke testified that CNs are expected to ensure the delivery of safe care to the patients, make certain that adverse changes in patients' health are reported to doctors, and supervise the implementation of doctors' orders. CNs also assist in the implementation of nursing plans, discharge plans, and patient teaching. They are expected to perform patient care as necessary and keep current on clinical issues. She further testified that CNs must demonstrate critical thinking skills and determine the nature and importance of situations and decide how to deal with them properly.

Burke indicated that many of the CNs' duties are similar to RNs' duties. In particular, both CNs and RNs receive and write medical reports, contact doctors when needed, and review patients' care plans and prioritize the listed items. Both RNs and CNs have contact with CMs, although CNs deal with CMs more frequently.

When Kokkalis serves as the CN in the CCU, she comes to work an hour before her scheduled shift to prepare. During that time, she speaks with the CN from the prior shift concerning the unit's patients, makes patient assignments for the nurses, inspects the equipment, counts the narcotics, checks the temperature of the refrigerators, and completes a CN checklist. As CN, Kokkalis also acts as a Code Nurse, the designated nurse who responds to resuscitation emergencies. At the end of the shift, Kokkalis gives a report to the incoming CN as to the patients' status and inputs each patient's acuity, based upon a standardized classification system, into the Employer's computer. In addition, she must document the staff's presence during the shift, including the number of nurses and per-diem RNs, the amount of overtime, and other financial and budgetary information. Both CNs and RNs fill out incident reports whenever anything adverse happens to a patient.

RN Petro works as a CN on the day shift in a telemetry unit when the Assistant Director is not present. Her first task is a heart monitor check. She then prepares other equipment for the shift, including code sheets, patches, oxygen, and suction, and completes the relevant paperwork. Petro then reviews the reports from the prior shift and the new laboratory results and physicians' orders. She communicates the new laboratory results and orders to the relevant physician or nurse or to the CN on the next shift for follow-up. Petro testified that as the CN, she divides up certain tasks to the staff, such as telemetry checks and narcotic counts. To do so, she simply places a staff member's name on a list next to the task. CNs normally answer questions from doctors and direct them to the appropriate patients. If a doctor requests a test, the CN will communicate the doctor's directions to the appropriate secretary or RN. CNs and RNs are both responsible for keeping track of information derived from heart monitors. CNs review monitor strips, which contain patient heart information, for all 32 monitors in the unit, record the information, and secure the strips in a book. If one of the monitors indicates a patient crisis, the CN will ask other RNs to check the patient, and they will tell the CN the patient's status. The CN then may contact the House Physician about the problem or may call a telephone code indicating an emergency. At the end of the shift, the CN collects patient records created by the RNs and places them in the appropriate binders.

Vice-President of PCS Burke testified that on the night shift in a telemetry unit, the CN is the highest-ranking employee in the unit because the Director and Assistant Director are not at

work.[8] Similarly, a CN may at times be the highest-ranking employee in the CCU.[9] The hospital has general guidelines requiring the CN, when she is the highest-ranking employee on a unit, to contact the House Supervisor if there are any significant patient issues.[10] For example, if a patient was rapidly deteriorating, the attending RN would alert the CN, and the CN or the RN would decide whether to contact the House Physician. After the House Physician examines the patient, the CN would contact the House Supervisor. The CN also prioritizes new orders which accumulated at the unit prior to her shift and determines which ones need to be acted upon first. CNs are also responsible for the narcotics in their units.

*Selection and Training of CNs*

Dodds testified that to become a CN in one of her units, an RN must serve in the unit for at least one year, be certified in telemetry, and take critical care courses and a CN workshop. RNs who choose to serve as CNs in Dodds' units are selected based upon observations by the supervisors. She testified that becoming a CN is generally voluntary, although she has encouraged RNs to participate in the training. Burke also testified that CN training is not mandatory.

According to Burke, to train as CNs, RNs participate in a two-day orientation program, after which an experienced CN reviews a checklist of duties with them over a two to three-day day period. The checklist includes 20 items, including, inter alia: checking staffing for the oncoming shift; preparing patient assignments; assigning staff lunches in a timely manner; reviewing physicians' orders and communicating changes to the staff; assigning new admissions and transfers based on the acuity of patients and activity of the unit; responding to all doctor and family concerns; prioritizing workload; and giving a detailed report to the oncoming shift.

RN Kokkalis testified that her orientation and training program in the CCU was mandatory. She stated that it was supposed to last for one 12-hour shift, but she requested and was given an additional day to become comfortable with the additional responsibilities. RN Petro testified that after two or three months at the hospital, she was told that she was going to be trained as a CN and that her training lasted for three days. RN Heuschkel testified that she was trained by two senior CNs and the Assistant Director.

*Assigning Staff to Patients*

CNs assign staff to patients based on various factors. For one, patients with certain conditions can only be assigned to RNs because they are permitted to provide particular types of

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[8] Although Burke focused her testimony on the night shift, she testified that the CNs' duties during the day are essentially the same, except that there is more activity, including laboratory reports, doctor visits, and medical testing. In addition, the Director and Assistant Director are present during the day, so the CN is not the highest-ranking staff member on the unit.

[9] The record does not indicate how frequently CNs are the highest-ranking employees in their units throughout the hospital.

[10] The House Supervisor is a Director who is in charge of the hospital on weekends. The Directors each serve in this capacity several times a year.

care that LPNs are not certified to provide. In particular, LPNs may not perform various procedures involving intravenous medications. Additionally, the CN considers where the patient is located, because it is more efficient for a nurse to have patients located near each other. CNs also attempt to continue to assign staff to the same patients to maintain their continuity of care.

Burke and PCS Director Dodds testified that CNs also consider the ability and experience of RNs in making patient assignments. Burke indicated that CNs try to assign patients based on their location but that they may have to break up a grouping by location because of patient acuity. She noted that during the day, as patients are admitted and discharged, a CN will try to avoid giving new patients to nurses who already have heavy loads. She further indicated that a CN should either refrain from giving certain types of patients to novice nurses or watch them very closely. Dodds stated that a CN should not assign an inexperienced RN to a patient on a ventilator and a cardiac drip but would give that patient to a more experienced nurse.

In contrast, RNs Kokkalis, Petro and Heuschkel stated that they do not consider an RNs' skill or experience when assigning patients. Kokkalis testified that she assumes that nurses in the CCU all passed the required competency tests and are capable of working with any patient. Similarly, Petro testified that she believes that RNs should be able to perform all necessary work. Heuschkel stated that she makes assignments by dividing the number of patients by the number of nurses on duty and grouping patients by geographic location. She assumes that all RNs are capable of performing all functions.[11]

*Overstaffing, Understaffing, and Overtime*

CNs have certain duties regarding overstaffing and understaffing of units. As noted above, the units have scheduling grids which identify the number of patients that are allowed in a unit and the corresponding number of staff. Vice-President of PCS Burke testified that the CN is required to seek volunteers to go home if the unit is overstaffed, and if there are no volunteers, staff members can be chosen to go home on a random basis, such as by selecting names from a hat. The CN may also check with nearby units to see if a nurse can be sent to help at those units rather than being sent home. Some of the units are "closed," however, which means they can not have staff transfer in from other units. PCS Director Dodds testified that the grid ratios are used to determine if a unit is overstaffed. In Dodds' units, there are written guidelines which state that when a CN seeks volunteers to leave, she should first consider per-diem employees and employees who are working overtime.[12] In deciding which employee to send home, the CN should try to ensure that the nurses who remain are experienced and capable enough to handle the patients in the unit. She further testified that CNs are authorized to make decisions concerning the staffing levels in her units without seeking permission from the Director, as long as those decisions are consistent with the scheduling grid.

[11] Heushkel stated, however that she will try not to give one nurse more than one isolation room. In one case, after being assigned some work, a nurse in her unit informed her that she did not pass her arrhythmia training, and Heuschkel had to monitor and approve the work.

[12] These guidelines were not submitted into evidence.

The CNs who testified on this subject stated that when a unit is overstaffed, the CN would either seek volunteers to go home or select staff members at random. RN Kokkalis testified that the CCU is rarely overstaffed, but in those circumstances the Director will instruct the CN to find volunteers to go home. If the Director or Assistant Director is not on the unit, she will not send staff members home. Petro testified that if the telemetry unit is overstaffed, she finds out the activity in the Emergency Room and contacts the House Supervisor to discuss the matter.[13] If there are a lot of patients in the Emergency Room, the House Supervisor and the CN may call the Director and seek permission to maintain the additional staff. If not, the House Supervisor directs the CN to seek volunteers to leave.

Dodds testified that when her units are understaffed, a CN can make the decision to call in more staff based upon patient acuity. There is an availability list that is used to help determine which nurse to call, but the CN could call anyone who will come in, and the CN determines which type of staff member to call in. Burke hypothesized that if she were a CN, she would call in an RN if understaffed. She stated that she would prefer a more experienced RN for the night shift but she would take "whatever nurse [she] can get." If a staff member is called in because of understaffing on a unit she will receive overtime pay. According to Burke, the CN must call a supervisor for authorization of overtime pay, but the supervisor will virtually always give this approval. Dodds testified that CNs in her units may grant overtime pay to employees, but only if such assignments conform to the staffing grid ratios.

RN Kokkalis testified that when she is a CN and the unit is understaffed, she seeks permission from the Director to secure additional personnel. Kokkalis does not ask for additional staff often. She justifies the need for additional staff to the Director based upon the scheduling grid and the acuity of the patients. The Director then decides whether to give Kokkalis permission to seek additional personnel. The Director has sometimes denied her requests.[14] RN Petro testified that as a CN, she may not authorize overtime for employees.

*Lunches and Breaks*

The scheduled times for staff members' lunch periods and other breaks vary so that there are always a sufficient number of staff members working in each unit. However, there is a range of times during which the lunch periods and breaks are scheduled. Vice-President Burke testified that CNs assign lunches and breaks and that a CN may switch staff members' lunchtimes to accommodate other employees' schedules. RN Kokkalis testified that she occasionally assigns lunches and breaks to RNs, but the RNs usually assign themselves to lunches and breaks before Kokkalis does it.

*Discipline*

RNs Kokkalis and Petro both testified that CNs do not issue any discipline, but Vice-President Burke recounted an incident in which a CN was involved in a disciplinary matter.

[13] Presumably, many telemetry patients arrive after spending time in the Emergency Room.

[14] It is unclear from the testimony if Kokkalis had asked for more staff once or twice in the last two years, or if her request had been denied that many times in that period.

After an NA left the unit without permission several times, staff members reported the problem to the CN, who discussed the matter with the NA. When the problem persisted, the CN reported the matter to the Director, the Director spoke to the NA, and Burke personally became involved. The record does not disclose what, if any, discipline was imposed on the NA.

Burke indicated that CNs have the authority to remove staff members from their units if necessary. She testified that if a staff member acted as if she was under the influence of drugs or alcohol, or had a mental breakdown, the CN would be responsible for removing that staff member to the nursing lounge or office and contacting the Director or House Supervisor. The employee would then be encouraged to submit to drug or alcohol testing at the hospital and if the employee tested positive, he or she would be sent home. CNs can also send home employees if they are ill.

*Wages and Benefits*

The parties stipulated that the minimum wage rate for RNs is $23.19 per hour, and the maximum wage is $35.77 per hour. CNs earn one dollar more than RNs per hour. RNs and CNs are eligible for overtime pay and for a pay differential based upon their RN level and seniority.[15]

CNs and RNs are entitled to the Employer's benefits package, which includes medical insurance, dental benefits, legal services, life insurance, retirement, and awards for perfect attendance. Full-time employees are entitled to receive the entire package with no contribution by the employee, while part-time employees do not get dental benefits and must make contributions for the other benefits.

There is no record evidence as to the per-diem RNs' wage rates. They are not entitled to benefits.

## D. Analysis

I find that the Employer has failed to establish that the CNs are supervisors within the meaning of Section 2(11) of the Act. In particular, the Employer has not met its burden to demonstrate that the CNs exercise independent judgment in making assignments to staff members or that they responsibly direct other employees.

*Assignment of Staff*

CNs do not assign the staff members to their shifts. Staff members' schedules are determined by each unit's Director or Assistant Director based upon the grid listing the proper ratio of patient per employee for each shift.

[15] There are three pay levels for the Employer's RNs, including the CNs and CMs. The pay levels are based on the employees' experience and certifications.

There is conflicting evidence concerning the CNs' assignment of the scheduled staff members to patients. Burke and Dodds stated that CNs consider the RN's competency and the patients' acuity when making staff assignments. All three RNs who testified on this point, however, stated that when serving as a CN, they assume that all RNs in their units are qualified to handle all patients, and they make patient assignments without regard to the qualifications of the particular nurses. Rather, they consider only non-discretionary factors such as the location of the patient's room, whether the nurse had previously cared for the patient, and whether the patient requires care that only an RN is certified to perform.

Making assignments based upon room location, continuity of care, and equalization of the workload is essentially routine and not indicative of supervisory status. *Loyalhanna Care Center,* 332 NLRB 933, 935 (2000); *Youville Health Care Center*, 326 NLRB 495, 496 (1998*); Crittenton Hospital*, 328 NLRB 879, 882 (1999). However, to the extent the assignments are based on assessments of the employees' relative skills, such assignments require independent judgment and therefore are supervisory. *Franklin Hospital Medical Center,* 337 NLRB 826, 830 (2002). On the other hand, an employee is not deemed a supervisor based on such assignments if he or she assigns tasks based on employees' well-known differing abilities. *Hausner Hard-Chrome of KY, Inc.,* 326 NLRB 426, 427 fn. 7 (1998).

Consistent with the Board's imposition of the burden on the party asserting supervisory status, the Board will not normally find supervisory status when the evidence is in conflict or otherwise inconclusive on a particular indicia of supervisory authority. *Kentucky River*, supra, 532 U.S. at 711 (2001); *Franklin Hospital Medical Center,* supra, 337 NLRB at 829; *Crittenton Hospital,* supra. In this case, the testimonial evidence is in conflict, and the Employer did not provide documentary evidence of the criteria to be used by CNs when assigning patients. Additionally, the only specific criteria to which the witnesses referred was that they would not assign a novice nurse to a highly acute patient. In these circumstances, I find insufficient evidence that CNs generally make assignments by matching individual nurses' skills to the patients, other than factoring in obvious differences in experience levels and certifications, and therefore these assignments do not require independent judgment. Accordingly, I do not find that assigning staff to patients confers supervisory status on the CNs.

*Overstaffing, Understaffing, and Overtime*

There is also conflicting testimony regarding the CNs' authority to correct overstaffing and understaffing problems. All of the nurses who testified on the subject stated that CNs determine whether the unit is overstaffed based on the numbers set forth in the grid, and they seek volunteers or randomly determine who should leave, thus not considering the relative skills of the staff members. Applying these factors does not require a CN to use any discretion. Director Dodds testified that in soliciting volunteers to leave, a CN should first look at staff members who are on overtime and per-diem employees. She also testified that CNs should ensure that the remaining staff members are sufficiently competent to handle the patients, but she did not provide any documentary evidence or specific examples of this authority. Therefore, I find that the Employer's testimony does not outweigh the specific first-hand testimony of the CNs and that the Employer has not met its burden to establish supervisory authority based on their resolution of overstaffing problems.

RN Kokkalis and Director Dodds testified that in understaffed units, CNs consider the acuity of the patients when determining whether to seek more staff. Kokkalis testified that she does not seek such personnel often, and there is no evidence to the contrary. She further testified that she would seek more staff through a request to the Director of her unit, while Dodds testified that the CN need not seek permission from the Director. Petro stated that she will recommend to the Director that her unit maintain more RNs on duty if the Emergency Room is crowded. Burke stated that she would contact any nurse that she thinks will come to work, although she would prefer a more experienced RN on the night shift. There is no evidence that employees are required to come in to work when contacted in these circumstances; rather it appears that they have the right to refuse such requests.

Seeking voluntary help when short-staffed does not establish supervisory authority. See *Harborside Healthcare,* 330 NLRB 1334, 1336 (2000); *Youville Health Care Center*, supra, 326 NLRB at 496. Moreover, there is no evidence that CNs use significant discretion in deciding which employees to call in. Rather, they generally seek the first available staff member, although they may prefer a more experienced employee. The Board has further noted that the fact that an employee who is called in to work may receive overtime pay is incidental and not determinative of supervisory status. *Lakeview Health Center,* 308 NLRB 75, 79 (1992). At most, the CNs are involved with determining whether more staff is needed, and the Employer has not demonstrated that they can do more than make recommendations to the Director. Finally, an individual will be deemed a statutory supervisor only if he or she functions in a supervisory capacity on a regular and substantial basis. See *Rhode Island Hospital,* 313 NLRB 343, 348 (1993); *Gaines Electric Company*, 309 NLRB 1077, 1078 (1992). Since the record does not indicate that the CNs regularly seek additional personnel, their authority to call in employees to remedy understaffing does not establish supervisory authority.

There is insufficient evidence to show that CNs use independent judgment in offering overtime to employees. Thus, while Director Dodds testified that CNs in her units may grant overtime, she stated that they may not exceed the staffing grid ratios, and RN Petro testified that she is not authorized to grant overtime at all when she serves as a CN. The Employer provided no evidence as to how frequently CNs assign overtime and how CNs select which employee should be offered overtime. Thus, the evidence as to whether or not CNs have the authority to offer overtime is in conflict and cannot form the basis for a supervisory finding. See *Phelps Community Medical Center,* supra, 295 NLRB at 490. Finally and most important, there is no evidence that nurses can be required to work overtime, and requesting an employee voluntarily to work overtime is not indicative of supervisory status. *Ryder Truck Rental,* 326 NLRB 1386, 1387 (1998); *Esco Corp.,* 298 NLRB 837, 839 (1990).

*Lunches and Breaks*

The Employer similarly has not demonstrated that CNs use discretion in assigning breaks and lunch periods for employees. Staff members sometimes select their own lunch and break times. While CNs may assign and switch lunch periods and breaks, there is no evidence that in making these assignments, the CNs do anything other than rotate staff members within the time periods listed on the grid. Such authority is routine and does not require the exercise of

independent judgment sufficient to accord supervisory status. *Youville Health Care Center, Inc.*, supra at 496; *299 Lincoln Street, Inc.*, 292 NLRB 172, 183 (1988).

*Responsible Direction*

The Employer contends that the CNs responsibly direct their units, but the record does not support this assertion. Thus, a CN's assignment of discrete tasks to staff members, such as narcotic counts and telemetry checks, is better characterized as a routine function than a duty that requires independent judgment. *Franklin Hospital Medical Center*, supra, 337 NLRB at 831. In that case, the Board also found that the employer failed to show that staff RNs were fully accountable for the performance of their subordinates because the record did not include disciplinary warnings and evaluations to nurses who failed to direct the work of other employees. Similarly, there is no such evidence here. Also see *Loyalhanna Care Center*, supra, 332 NLRB at 935. Cf. *Schurnmacher Nursing Home*, 214 F.3rd 260, 267 (2d Cir. 2000). Burke's claims that CNs demonstrate "critical thinking" and supervise the implementation of doctors' orders are conclusory statements which, without supporting evidence, do not demonstrate supervisory authority. See *Sears Roebuck & Co.*, 304 NLRB 193 (1991). Additionally, the Board has found that rotating "supervisors," who at times are in charge of coequal employees, but at other times are subordinate to their coequals, are not supervisors. See *General Dynamics Corp.*, 213 NLRB 851, 859 (1974); *Westinghouse Electric Corp. v. NLRB*, 424 F. 2d 1151, 1155-1156 (7th Cir. 1970). Cf. *Wurster, Bernardi & Emmons, Inc.*, 192 NLRB 1049, 1051 (1971).[16] The Employer further relies on the one incident of a CN chastising an NA for repeated absence from the unit as demonstrating responsible direction. However, this incident was not fully explained in the record and in any case does not establish that CNs exercise supervisory authority on a regular and substantial basis.

*Discipline*

The CNs testified that they do not issue any discipline to employees, and the record includes only the incident involving the NA who was absent from the unit. The record does not show whether the CN recommended that the employee be disciplined and does not indicate that the NA actually was disciplined in any way that would have an effect on the employee's job status or tenure. Mere reporting of poor conduct does not establish supervisory status, especially here, where the Director may have independently investigated the matter. See *Williamette Industries*, 336 NLRB 743, 744 (2001). Moreover, an individual will be deemed a supervisor only if he or she functions in that capacity on a regular and substantial basis, and an isolated incident can not provide the basis for a supervisory finding. *Rhode Island Hospital*, supra, 313 NLRB at 348; *Gaines Electric Company*, supra, 309 NLRB at 1078. Here, the evidence

[16] In that case, architectural employees who sometimes worked as team leaders were found not to be supervisors where they responsibly directed other employees "only in a professional sense and related to a particular project." That finding is called into question by the Court's *Kentucky River* decision, which found that direction of other employees may be found supervisory even where it is based on an employee's exercise of professional judgment.

discloses only a single incident relating to discipline and is thus insufficient to establish supervisory authority. See *Kanawha Stone Co*., 334 NLRB 235, 237 (2001).

Although Burke testified that a CN can send a staff member home if the employee is suffering a mental breakdown or under the influence of alcohol or drugs, there is no written evidence, and no examples on the record, to confirm that CNs have this authority. Moreover, the authority to send employees home for flagrant violations such as patient abuse or intoxication does not constitute supervisory authority because it does not require the use of independent judgment. *Michigan Masonic Home*, 332 NLRB 1409, 1411 fn. 5 (2000); *Lincoln Park Nursing Home*, 318 NLRB 1160, 1162 (1995). Similarly, the authority to allow employees to go home when they are ill is not indicative of supervisory authority. See *Health Resources of Lakeview*, 332 NLRB 878, 879 (2000); *Lakeview Health Center*, supra at 78 (1992).

*Secondary Indicia*

The fact that RNs earn one dollar more per hour when they serve as CNs does not show supervisory status. See *First Western Building Services*, 309 NLRB 591, 603 (1992). In this regard, secondary indicia alone do not demonstrate supervisory status in the absence of the primary indicia set forth in Section 2(11). See *Ken-Crest Services*, 335 NLRB 777, 779 (2001).

At times, when the Director and Assistant Director are not present, the CN is the highest-ranking employee physically in the unit. However, the record shows that even in those cases, the CN must clear significant decisions with higher management. Additionally, the Board has held that if the highest-ranking employee in an area does not possess supervisory authority, the absence of anyone else with such authority does not confer supervisory status. See *Ken-Crest Services*, supra at 779 fn. 16 (2001); *Training School at Vineland*, 332 NLRB 1412 (2000).

Based upon the foregoing, I find that the Employer has not satisfied the burden of proving that CNs possess the indicia of supervisory authority set forth in Section 2(11) of the Act.[17] Cf. *NLRB v. Attleboro Associates, Inc*., 176 F. 3rd 154 (3rd Cir. 1999).

## III. CASE MANAGERS

### A. Factors Relevant To Determining Whether the Petitioned-For Unit is Appropriate

[17] Notwithstanding my conclusion that there is insufficient evidence to establish the supervisory status of the CNs, I reject the Employer's position that if CNs were deemed statutory supervisors, RNs who work as CNs more than 33 percent of the time should be excluded from the unit. The Employer failed to supply any legal justification for this threshold, and I know of none. As noted above, an individual will be deemed a statutory supervisor if she functions in a supervisory capacity on a regular and substantial basis. *Rhode Island Hospital*, supra, 313 NLRB at 348; *Gaines Electric Company*, supra, 309 NLRB at 1078.

The Board's procedure for determining an appropriate unit under Section 9(b) is first to examine the petitioned-for unit. If that unit is appropriate, the inquiry ends. *Dezcon, Inc*., 295 NLRB 109, 111 (1989). If the petitioned-for unit is not appropriate, the Board may examine the alternative units suggested by the parties, but it also has the discretion to select an appropriate unit that is different from the alternative unit proposals of the parties. See *The Boeing Co.,* 337 NLRB 152, 153 (2001); *Bartlett Collins Co.,* 334 NLRB 484 (2001). The Board generally attempts to select a unit that is the smallest appropriate unit encompassing the petitioned-for employee classifications. See *Overnite Transportation Co.*, 331 NLRB 662, 663 (2000). It is well settled that the unit need only be *an* appropriate unit, not the most appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 418 (1950), enfd. on other grounds 190 F.2d 576 (2d Cir. 1951). In determining whether a group of employees possesses a separate community of interest, the Board examines such factors as the degree of functional integration between employees, common supervision, skills and job functions, contact and interchange, and similarities in wages, hours, benefits, and other terms and conditions of employment. See *Home Depot USA*, 331 NLRB 1289 (2000); *Kalamazoo Paper Box Corp.*, 136 NLRB 134, 137 (1962).

The Board's Rule for determining appropriate bargaining units in the health care industry, 29 CFR §103.30, states that, absent extraordinary circumstances, only the following units shall be appropriate in acute-care hospitals: (1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.[18] 54 Fed. Reg. 16336 et seq.; 284 NLRB 1579, 1597 (1989). The Board intended that the "extraordinary circumstances" exception would be limited to truly extraordinary situations and be construed narrowly so it could not be used as an excuse for unnecessary litigation or delay. See 54 Fed. Reg. 16344-16345, 284 NLRB at 1593, 53 Fed. Reg. 33904, 33932, 284 NLRB at 1533, 1573; 52 Fed. Reg. 25145, 284 NLRB at 1521.

## B. Facts

*Job Duties, Responsibilities, and Working Conditions*

The Employer employs about 31 CMs, all of whom are licensed RNs. The job description indicates that a CM is, "A registered nurse who will coordinate the care of a group of patients across the continuum of care. Responsible for optimizing patient outcome within appropriate time frames and for facilitating the proper use of resources." The CM job description further states that the position is non-supervisory. The Employer's CMs have five major functions: quality review, utilization review, care coordination, discharge planning, and benefits coordination.

Regarding quality review, CMs evaluate the care the patients receive in comparison to established quality of care standards. If they find the care to be below standard, they investigate the problem. For example, if a patient needs to return to the operating room 24 hours after surgery, the CM may investigate the circumstances and prepare a report determining if such

[18] The Rule also exempts existing non-conforming units, an exception not relevant in this case.

conduct was consistent with established standards. If the conduct does not meet standards, the CM may alert the hospital's Risk Manager, the Director of PCS, or the Vice President of QS.

In the utilization review process, the CM determines whether the patient was underserved or overserved by the hospital. For example, if a patient exhibits symptoms warranting a medical consultation which was not performed, the CM would bring the matter to the attention of the appropriate physician or the physician advisor. Conversely, if a patient appears to be healthy enough to be discharged from the hospital, the CM may investigate the situation and speak to the physician and physician advisor to determine whether home care or less costly options are appropriate.

In discharge planning, the CM will review and analyze the circumstances under which the patient's family functioned prior to the hospitalization, the effect of the hospitalization on the family's care needs, and the best place for the patient to recover after discharge. To this end, the CM is in close contact with the patient, the patient's family, and the staff that cares for the patient. The CM makes arrangements with outside service providers, including ambulatory services, rehabilitation facilities, assisted care facilities, and nursing homes.

Care coordination involves the flow of care to the patient during his or her stay at the hospital. CMs attempt to ensure proper patient care through direct contact with the departments that are providing the care. For example, if a series of scheduled x-rays appears to have been ordered out of sequence, the CM would ask to have the schedule changed so that the patient would receive the medical procedures at the proper time. CMs have the authority to determine the pace of prescribed medical procedures, as well as to suggest additional procedures, such as physical therapy. CMs sometimes make decisions by themselves concerning the proper course of patient care and sometimes discuss their decisions with Vice President of QS Conarty. RNs can also make some of these decisions. For example, both a CM and an RN can order a physical therapy evaluation based upon certain clinical triggers.

In benefits coordination, the CM explores the different medical insurance plans that are available to the patient, including insurance for the patient's spouse or partner, to maximize the patient's benefits. In this role, the CM may contact the managed care provider, the insurer, and the after-care provider. For example, in a trauma case the CM might advocate for a nursing home to be paid whatever a bed costs, in addition to the daily rate that the insurance company is willing to pay, so that the patient can receive care at the designated facility.

CMs generally work Monday through Friday and also work one out of every six or seven weekends. They are each assigned to a nursing unit and have a patient load of about 17 to 22 patients. The larger nursing units may have more than one CM. Some of the CMs have had previous supervisory experience and about eight or nine of them have previously served as Directors.

Two CMs regularly spend time in RN Petro's telemetry unit, and both are present during the day shift. The CMs have a desk and an office in the unit. They review patient charts and discuss the status of patients with the RNs. They also speak to the CN about various matters.

RN Kokkalis testified that the CM in the CCU has an area in the unit specifically designated for her. She makes patient rounds every morning, speaks to RNs about patients, and helps RNs with patient discharges. The CM and the RNs typically discuss matters such as the status of a patient, if the patient has had certain medical tests, whether the patient is stable enough to be transferred from the unit, if the patient can be discharged, and if physical therapy has been ordered. CMs attempt to hasten the departure of patients, where warranted, in order to save hospital resources. CMs also speak with doctors concerning transfer orders and contact different hospital departments to expedite certain medical procedures like CAT-scans. The CMs use the same patient charts and computer system as the RNs in the unit.

Vice-President of QS Conarty testified that CMs control the time that they start work, depending upon the needs of the units in which they work. For example, CMs in the surgical unit come in early to make rounds with the staff, while CMs in the medical unit come in later to coincide with the staff schedules in that unit. The range of starting times for CMs is from about 6:45 a.m. to 9:00 a.m., and the ending times range from 4:00 p.m. to 6:00 p.m.

*Contact, Integration, and Interchange With Other Employees*

Each CM has his or her own office in the Bell Building. The amount of time that CMs spend in that office varies on a daily basis, but every day they spend at least some time in the hospital. As noted above, CMs spend a significant portion of their workday in their respective hospital units discussing patient needs with CNs, RNs, doctors, medical technicians, and patient families. In fact, CMs have specifically designated work spaces in the hospital.

CMs do not interchange positions with staff nurses. However, RNs from the Employer have applied for, and obtained, CM positions. Both RNs and CMs are deemed essential personnel, and CMs may be required, within their skill limits, to perform RN duties in essential personnel situations.

*Supervision and Wages and Benefits*

CMs report to the Director of Case Management, who reports to Conarty. The position of Assistant Director of Case Management is currently vacant.

The minimum wage for CMs is $28.10 per hour, the maximum wage is $41.26 per hour, and the average wage is $33.01. The CMs are salaried and therefore are not entitled to overtime pay. The differential between the average wages of the RNs and the CMs is $3.60 per hour, or 12.02 percent. The CMs are entitled to the same benefits package as the RNs.

The Employer has a "peer review" process, which is a procedure giving employees opportunities to pursue issues that concern them. CMs are not eligible for peer review.

*Commitment of Hospital Funds*

In discharge planning, CMs sometimes face situations in which traditional insurance companies do not cover all necessary costs patients will incur following discharge from the

hospital. For example, a patient may need private home care for two or three days before a relative is ready to move in with him. In such situations, the CM will commit hospital funds to pay for the home care. They may also commit funds for an ambulance, wheelchair, or intravenous therapy as needed. These payments are expected to be lower than the cost of maintaining the patient in the hospital.

About 75 percent of the Employer's hospital patients are covered by Medicare, which does not always cover a patient's full stay. If a CM determines that for safety reasons a patient needs to remain at the hospital beyond the time for which the Employer can receive Medicare reimbursement, the Employer may have to cover the costs itself.

### C. Analysis

The Board's Health Care Rule requires that all RNs be included in the same unit, in the absence of extraordinary circumstances. There are no extraordinary circumstances in this case. Rather, the CMs share a community of interest with the other RNs and clearly belong in the RN unit.

All of the Employer's CMs are RNs who regularly work and interact with the other employees in the petitioned-for unit. They have frequent contact with staff in all patient care departments, including nursing personnel, and they regularly communicate with RNs concerning their patients and coordinate different aspects of their care. In fact, CMs have work spaces assigned to them in the hospital departments because they spend a significant amount of time there working with the units' staffs. CMs may even alter their work schedules in order to facilitate communication between them and unit staff members.

In addition, CMs share some terms and conditions of employment and responsibilities with employees in the petitioned-for unit. They are entitled to the same benefits package as the RNs and also perform some of the same job functions, such as ordering physical therapy evaluations based upon certain clinical triggers. CMs use the same patient chart and computers as the RNs in performing their job duties, and they both communicate with physicians, NAs, technicians, patients, and families regarding discharge planning. They are all deemed essential personnel by the Employer.

There are several factors militating against a community-of-interest finding. CMs and RNs are separately supervised, and CMs generally work about eight hours per day, while most RNs work 12-hour shifts. Unlike the other RNs, CMs are based in the Bell Building and report to work there each day. In addition, there is little interchange between the two positions, the CMs unlike the RNs are salaried, and their pay ranges differ by about 12 percent. These factors, however, are outweighed by those in favor of finding a community of interest between the CMs and the RNs. Moreover, RNs have applied for, and obtained, CM positions and CMs can be required to perform RN duties in emergencies. See e.g. *Pocono Medical Center,* 305 NLRB 398, 398-399 (1991).

The Employer also contends that the CMs' duty to balance the requirements of quality patient care with budgetary concerns creates a conflict of interest between the CMs and RNs that

destroys their community of interest. However, RNs Kokkalis and Petro both testified that RNs also must balance nursing care and financial constraints. Moreover, the Board has held that where CMs, as well as discharge planners and utilization review coordinators, have RN licenses, they will be included in an RN unit. See *Salem Hospital,* 333 NLRB 560 (2001); *Pocono Medical Center,* 305 NLRB 398 (1991); *Middletown Hospital Assn.,* 282 NLRB 541, 578 (1986); *Frederick Memorial Hospital,* 254 NLRB 36 (1981); and *Trustees of Noble Hospital,* 218 NLRB 1441, 1445 (1975).[19] In an analogous situation, the Board has generally included quality control employees in units of production and maintenance employees, finding that their inclusion does not create a conflict of interest. See *Lundy Packing Co.,* 314 NLRB 1042, 1043 (1994) (citing *Blue Grass Industries,* 287 NLRB 274 (1987) and *W.R. Grace & Co.,* 202 NLRB 788 (1973)). In the instant case, as all CMs are licensed as RNs, they should be included on this basis.

As there are no extraordinary circumstances that would justify a departure from the units set forth in the Board's Healthcare Rule, I shall include them in the unit. Moreover, I find that the record amply demonstrates that the CMs share a community of interest with RNs based upon their regular interaction with RNs and because of the positions' similar terms and conditions of employment.

### D. Factors Relevant To Determining Managerial Status

Managerial employees are excluded from the coverage of the Act and are not entitled to be accorded bargaining rights. *NLRB v. Bell Aerospace Co.,* 416 U.S. 267, 289 (1974). Managerial employees are defined as those who formulate and effectuate management policies by expressing and making operative the decisions of their employer. To be considered managerial, an individual must exercise discretion within, or even independent of, established employer policy. *NLRB v. Yeshiva University,* 444 U.S. 672, 682-683 (1980). The determination of an employee's managerial status depends on the extent of his or her discretion, and an employee who exercises limited discretion, bordering on routine performance, will not be deemed managerial. *Eastern Camera & Photo Corp.,* 140 NLRB 569, 571 (1963).

The Board has traditionally viewed as managerial individuals who exercise discretion in making significant purchases on behalf of their employer. *ITT Grinnell,* 253 NLRB 584 (1980); *Simplex Industries, Inc.,* 243 NLRB 111, 112-113 (1979). The ability to commit an employer's credit in substantial amounts, especially when accomplished through the exercise of discretion that is not ordinarily reviewed, is strong evidence of managerial status. *Concepts & Designs, Inc.,* 318 NLRB 948, 956-957 (1995), enfd. 101 F.3d 1243 (8th Cir. 1996). Employees who make purchases on behalf of their employers will not be deemed managerial, however, where their discretion is restricted significantly by the employer's guidelines or the need to clear their decisions with higher authorities. *The Washington Post Company*, 254 NLRB 168, 189 (1981); *Bell Aerospace, A Division of Textron, Inc*., 219 NLRB 384, 386-387 (1975).

### E. Analysis

[19] The discharge planners and utilization review coordinators in those cases share many of the same responsibilities as the Employer's CMs.

As part of the discharge planning process, the CMs sometimes commit Employer funds to provide necessary services to patients upon discharge when they lack insurance coverage for these services. These funds are likely to cover services such as ambulances, wheelchairs or a few days of home care. There is no evidence as to how often these expenditures are required or how much money the CMs have actually committed, but it does not appear that they commit substantial amounts of money for these items. Additionally, the evidence does not indicate whether there are any monetary limitations on the CMs' extension of credit, a factor relevant to determining managerial status. See e.g. *Bakersfield Californian*, 316 NLRB 1211, 1218 (1995); *Reading Eagle Co.*, 306 NLRB 871, 872 (1992). The record also does not indicate whether there are Employer guidelines or required approvals that would restrict the CM's commitment of funds. See e.g., *Washington Post*, supra at 189 (1981).[20] Finally, the Board has deemed an individual not to be a managerial employee, even though he extends the employer's credit, because he plays no role in formulating the underlying policy related to the extension of the credit. See e.g. *People's Transportation Service*, 276 NLRB 169, 264 (1985). Here, the Employer failed to present any evidence regarding the CMs' role, if any, in formulating the Employer's policy. In summary, there is insufficient evidence concerning the amount and frequency of the CMs' expenditures and the restrictions on their authority. Without such evidence, there is no basis for concluding that the CMs commit the Employer's credit in sufficient amounts, with sufficient independence, or play a sufficient role in the policies underlying the expenditures, to conclude that the CMs act in a managerial capacity within the meaning of the Act.[21] Accordingly, they shall not be excluded from the unit as managerial employees.

## IV. CONCLUSIONS AND FINDINGS

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction in this case.

3. The Petitioner claims to represent certain of the employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

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[20] In that case, an assistant purchasing manager committed $25,000 to $50,000 of the employer's funds each month but was not found to be a managerial employee because there were significant restrictions on the employee's authority.

[21] At the hearing, the Employer suggested that CMs may also be statutory supervisors, but the Employer did not pursue this contention in its brief. In any event, the evidence does not establish that CMs are supervisors within the meaning of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time, regular part-time, and per-diem[22] Registered Nurses, including Charge Nurses and Case Managers, employed by the Employer at the Employer's Toms River, New Jersey locations, excluding the Acting Director, Administrative Clinical Coordinator, Administrative Director, Administrator for Nursing Services, Assistant Director, Assistant Director for Patient Care, Clinician Senior, Coordinator, Coordinator-Home Healthcare Aides, Director, Director of Patient Care, Educator RN, Employee Health Nurses, Executive Director, Family Health RN, Infection Control Practitioner, Intake RN, Manager-Adult Day Care Program, Massage Therapist, Patient Care Coordinator, Preadmission Testing RNs, Process Improvement RN, Program Analyst Senior, Protocol Nursing Data Manager, Quality System Analyst, Senior Administrative Clinical Coordinator, Supervisor-Radiation Oncology, Team Leader-System Business Office, Vice Presidents, and the Registered Nurses in the Family Health Unit and the Home Health and Hospice Department, all other employees, Licensed Practical Nurses, Nursing Assistants, Service Maintenance Technicians, guards and supervisors as defined in the Act.

## V. DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. The employees will vote whether or not they wish to be represented for the purposes of collective bargaining by **New York State Nurses Association**. The date, time, and place of the election will be specified in the Notice of Election that the Board's Regional Office will issue subsequent to this Decision.

### A. Eligible Voters

[22] The parties stipulated that only those per-diem RNs who worked an average of 24 hours biweekly in the period preceding this Decision and Direction of Election are eligible to vote. Based on their stipulation, I adopt this formula.

The Employer seeks to exclude from the unit all per-diem RNs who do not meet the voter eligibility formula. However, the Employer did not provide facts or authority to support its position, and the Board has included per-diem RNs in RN units based on a community of interest with other RNs. *Holliswood Hospital,* 312 NLRB 1185, 1197 (1993). Moreover, in *Franklin Hospital Medical Center,* supra at 826, 827 fn. 1, the Board adopted the Regional Director's rejection of a similar contention.

The eligible voters shall be unit employees employed during the designated payroll period for eligibility, including employees who did not work during that period because they were ill, on vacation, or were temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced are also eligible to vote. In addition, employees engaged in an economic strike that commenced less than 12 months before the election date, who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote. Employees who are otherwise eligible but who are in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are 1) employees who have quit or been discharged for cause after the designated payroll period for eligibility, 2) employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date, and 3) employees engaged in an economic strike which began more than 12 months before the election date who have been permanently replaced.

### B. Employer to Submit List of Eligible Voters

To ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to a list of voters and their addresses, which may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Company*, 394 U.S. 759 (1969).

Accordingly, it is hereby directed that within **seven** days of the date of this Decision, the Employer must submit to the Regional Office an election eligibility list, containing the ***full*** names and addresses of all the eligible voters. *North Macon Health Care Facility*, 315 NLRB 359, 361 (1994). The list must be of sufficiently large type to be clearly legible. To speed both preliminary checking and the voting process, the names on the list should be alphabetized (overall or by department, etc.). Upon receipt of the list, I will make it available to all parties to the election.

To be timely filed, the list must be received in the Regional Office, One Independence Mall, 615 Chestnut Street, Seventh Floor, Philadelphia, Pennsylvania 19106 on or before **February 22, 2005**. No extension of time to file this list shall be granted except in extraordinary circumstances, nor will the filing of a request for review affect the requirement to file this list. Failure to comply with this requirement will be grounds for setting aside the election whenever proper objections are filed. The list may be submitted by facsimile transmission at (215) 597–7658, or by E-mail to Region4@NLRB.gov.[23] Since the list will be made available to all parties to the election, please furnish a total of **two** copies, unless the list is submitted by facsimile, in which case no copies need be submitted. If you have any questions, please contact the Regional Office.

[23] See OM 05-30 dated January 12, 2005, for a detailed explanation of requirements which must be met when submitting documents to a Region's electronic mailbox. OM 05-30 is available on the Agency's website at www.nlrb.gov.

### C. Notice of Posting Obligations

According to Section 103.20 of the Board's Rules and Regulations, the Employer must post the Notices to Election provided by the Board in areas conspicuous to potential voters for a minimum of **three** working days prior to the date of the election. Failure to follow the posting requirement may result in additional litigation if proper objections to the election are filed. Section 103.20(c) requires an employer to notify the Board at least **five** working days prior to 12:01 a.m. of the day of the election if it has not received copies of the election notice. *Club Demonstration Services*, 317 NLRB 349 (1995). Failure to do so estops employers from filing objections based on non-posting of the election notice.

## VI. RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, NW, Washington, D.C. 20570-0001. A request for review may also be submitted by E-mail.[24] This request must be received by the Board in Washington by 5:00 p.m., EST on **February 28, 2005**.

Signed: February 14, 2005

at Philadelphia, PA

/s/
DOROTHY L. MOORE-DUNCAN
Regional Director, Region Four

[24] See OM 5-30, supra.